

E10/S/e

**NHS STANDARD CONTRACT
FOR COMPLEX GYNAECOLOGY: URINARY FISTULAE**

**PARTICULARS, SCHEDULE 2 – THE SERVICES, A - SERVICE
SPECIFICATIONS**

Service Specification No.	E10/S/e
Service	Complex Gynaecology: Urinary Fistulae
Commissioner Lead	
Provider Lead	
Period	12 months
Date of Review	

1. Population Needs

1.1 National/local context and evidence base

In this document the term 'lower urinary tract fistula' is taken to include any fistulous tract involving the bladder or urethra and the genital and/or gastro- intestinal tracts and peritoneal and/or cutaneous surfaces. Lower urinary tract fistulae in the UK are seen in a number of situations, but are most commonly iatrogenic, and occur following by pelvic surgery (68%) or radiotherapy (10%).[1] Hysterectomy is the most commonly associated surgical procedure (50% of all cases, 72% of surgical cases),[1] and the risk varies between approximately 1 in 4000 for vaginal hysterectomy for prolapse and 1 in 100 for radical hysterectomy for cervix cancer.[2] Approximately 120 cases undergo surgical treatment within the NHS in England annually,[3] and hence they fall within the definition of specialised services.

Despite clearly falling within the historic specialised services national definitions set (SSNDS), and professional support of the concept,[4-6] there has not previously been national recognition of specialised services for lower urinary tract fistulae or diverticula. As a result current patterns of care are inconsistent, with the majority of cases being managed in units undertaking very small numbers of cases (one procedure in 10 years) and a minority being undertaken in units of modest activity (only three consultant teams currently undertake more than 3 procedures per year).[3] Approximately 20-25% of the national workload is undertaken in a single unit.[1]

The arguments for centralisation of services for fistula management are overwhelming and data indicates that probably only 3 centres are required in

England to manage lower urinary fistulae. Surgical expertise and experience of the required range of surgical options is limited. Additional expertise from coloproctology and plastic surgery is essential to a comprehensive service, as are experienced nursing, physiotherapy, psychology, and patient support.

As indicated above, a majority of cases are currently managed in units undertaking very small numbers of cases (one procedure in 10 years). Over the last 10 years 281 consultant teams have managed only a single case each; these are primarily in the main specialty of Urology.[3] It is likely that these individuals look on fistula management as being sufficiently close to core Urology as not to require specific skills or workload.

It is clearly recognised that there is a need to move away from the current service model of commissioning small volume activity from multiple providers to implement a process of designation of providers who complete a minimum of 6 cases per year. This is likely to lead to the designation of 3 providers nationally. During the first year of implementation of this specification, local commissioning teams will be asked to map and report on providers and activity levels in their local areas and advise the Clinical Reference Group (CRG) on risks that will need to be managed during this transitional year and the processes that will be put in place to manage them, with a view to complete a designation process by March 2014.

2. Scope

2.1 Aims and objectives of service

The primary aims are:

- To provide a safe and effective care pathway for women with fistulae and diverticula
- To provide social, economic and psychological benefits for women requiring the service
- To provide continuity of care through the whole care pathway encompassing other specialised services included within the pathway

2.2 Service description/care pathway

Procedures required

(Those in italic text are relevant to both fistulae and diverticula)

Investigative:

- **Endoscopy:** *Cystourethroscopy (M45.1)*; (ureteroscopy (M30.4)); sigmoidoscopy (H25.1, H28.1); colonoscopy (H18.1)
- **Functional assessment:** *urodynamics (M47.4)*, ano-rectal manometry (H46.3), nerve conduction studies (A84.3)

- **Imaging:** CT/IVU (U37..2), MRI (U085, U09.3), ultrasound (Q55.5), retrograde pyelography (M30.1)

Initial drainage procedures:

- Urethral or suprapubic catheterisation of bladder (M47.8, M38.2)
- Retrograde ureteric stenting (M27.4), nephrostomy (M13.6), antegrade ureteric stenting (M33.4)

Repair surgery:

- *Vaginal repair of vesicovaginal fistula (+/- interposition) (P25.1)*
- *Vaginal repair of urethrovaginal fistula (+/- interposition) (P25.2; M73.3)*
- *Urethral reconstruction (+/- interposition) (M73.4)*
- Colpocleisis (+/- interposition) (M18.1, M18.2)
- Abdominal transvesical repair of vesicovaginal fistula (P25.1)
- Abdominal transperitoneal repair of vesicovaginal fistula (+/- interposition) (P25.1)
- Ureteric re-implantation or repair (M21.1-M21.9)
- Urinary diversion (ileal conduit or continent diversion) (M19.1, M19.8)

Multidisciplinary Team membership:

- Urogynaecologist or Urologist with training & expertise in fistula management
- Urogynaecology (if urologist above)
- Urology (if urogynaecologist above)
- Coloproctology
- Nursing
- Physiotherapy
- Access to:
- Nutrition (especially where bowel fistulae additionally managed)
- Psychology
- Patient Support Group
- *Diverticulum: Urogynaecologist or Urologist with training & expertise in urethral reconstruction*

In summary, the main diagnostic codes for this services are ICD10, N820 and N821 and operative codes are OPCS4, P251 and P252.

2.3 Population covered

The service outlined in this specification is for patients ordinarily resident in England*; or otherwise the commissioning responsibility of the NHS in England (as defined in Who Pays?: Establishing the responsible commissioner and other

Department of Health guidance relating to patients entitled to NHS care or exempt from charges).* - Note: for the purposes of commissioning health services, this EXCLUDES patients who, whilst resident in England, are registered with a GP

Practice in Wales, but INCLUDES patients resident in Wales who are registered with a GP Practice in England.

Specifically this service is for women experiencing any fistulous tract involving the bladder or urethra and the genital and/or gastro-intestinal tracts and peritoneal and/or cutaneous surfaces.

2.4 Any acceptance and exclusion criteria

The service will accept referrals from GPs and secondary care clinicians in Gynaecology and Colorectal surgery. The service will also accept referrals from other providers, particularly when the referring service is not designated to undertake the clinical role the service requires.

The service will accept referrals for patients who are experiencing any fistulous tract involving the bladder or urethra and the genital and/or gastro-intestinal tracts and peritoneal and/or cutaneous surfaces.

Exclusions

Patients with gynaecological cancer; their care is covered in the cancer services specifications

2.5 Interdependencies with other services

Urogynaecology. Urology, Coloproctology, Nursing, Physiotherapy, Nutrition and Psychology.

3. Applicable Service Standards

3.1 Applicable national standards e.g. NICE, Royal College

There are no currently available standards or evidence-based guidelines applicable in lower urinary tract fistulae from National Institute for Health and Care Excellence (NICE), Cochrane database or Royal College of Obstetricians and Gynecologists (RCOG).

An RCOG study group on incontinence published in 2002 made some recommendations on management and patterns of care.[6]

The recent 1st International Consultation on Obstetric Vesicovaginal Fistula and 5th

International Consultation on Incontinence reviewed current evidence on obstetric and non-obstetric fistula respectively; these are currently in press, but may be available for review as 'academic in confidence'.[7, 8]

The International Society of Obstetric Fistula Surgeons (ISOFS) has produced a number of standards for training, practice and centre accreditation in relation to obstetric fistula in the developing world;[9] in association with the Final International Federation of Gynecology and Obstetrics (FIGO), the same group have developed a training manual.[10]

The development of skill in the management lower urinary tract fistulae could NOT be expected to be achieved from core training or from Advanced Training Skills Modules in Gynaecology or Urology. A modular training including periods in Urogynaecology, Urology and Coloproctology (as provided in some RCOG accredited Urogynaecology subspecialty training programmes), preferably supplemented by an attachment to a fistula unit overseas would be necessary.

Maintenance of skill requires the regular and consistent involvement in the management of a range of gynaecological and urological conditions, and a minimum of 3 and optimally 10 cases of lower urinary tract fistula per year.

4. Key Service Outcomes

Results from treatment of lower urinary tract fistula vary widely in published literature. A recent analysis of outcomes from the Hospital Episode Data (HES) database indicates re- operation rates varying between 0% and 50%.[3] Those units undertaking more than 30 procedures over 10 years achieved a significantly lower re-operation rates than those undertaking lower numbers (7.4% vs. 13.2%).[3]

Although primary fistula repair is appropriate in most cases, a small number may require urinary diversion; this is more likely in women with gynaecological malignancy. The rate of urinary diversion in women with a diagnosis of lower urinary tract fistula also varies considerably, and may be seen as another measure of outcome. The overall rate of diversion in England is 25.5%,[3] whereas in the unit undertaking the largest number of fistula repairs nationally, the rate of diversion was only 2.7%.[1]

References:

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4. Hilton P. Debate: 'Post-operative urinary fistulae should be managed by gynaecologists in specialist centres'. *British Journal of Urology.* 1997;80:35-

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5. Hilton P, Hendry WF. Urogynaecology Proceedings of the Joint RCOG/BAUS Urogynaecology Meeting - 19 September 1996 - Preface. British Journal of Urology. 1997;80:R5-R.
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 7. International Consultations on Urological Diseases. First ICUD-SIU International Consultation on Obstetric Vesico-Vaginal Fistula. Abrams P, editor. Plymouth, UK: Health Publications; 2012. (in press).
 8. de Ridder D, Hilton P, Mourad S, Pickard RS, Rovner ES, Stanford E. Fistulae. In: Abrams P, Cardozo LD, Wein A, editors. Incontinence – ICUD-EUA 5th International Consultation on Incontinence. Plymouth, UK: Health Publications; 2012. p. (in press).
 9. International Society of Obstetric Fistula Surgeons. Standards. 2012; Available from: <http://www.isofo.org/standards/>
 10. International Federation of Gynecology & Obstetrics and Partners. Global competency based fistula training manual. London: FIGO; 2011. Available from: http://www.figo.org/files/figo-corp/FIGO_Global_Competency-

Service Pathway – Complex Gynaecology
Lower urinary - genital tract fistulae; urethral diverticula*
**n.b. Where pathways differ, that for diverticula is shown in blue text*

Referral Pathway type/source	Service Delivery	
	<p align="center">Primary General Gynaecology; Urogynaecology; Urology; General</p>	<p align="center">Secondary As primary; probably deferred by >3 months</p>
Outpatient Appointment (Detail? Assessment, MDT, Single Clinician etc)	<p>Local referrals - Initial out-patient appat at Supra-regional Urogynaecology/Urology Fistula Unit</p> <p>Regional/Supra regional referrals - Admission to Supra-regioanl Urogynaecology/Urology Fistula Unit</p>	
	<p>Urogynaecologist or Urologist with training and expertise in fistula management working with MDT including Urogynaecology, Urology, Coloproctology, Nursing, Physiotherapy, Patient Support Group Diverticulum: Urogynaecologist or Urologist with training and expertise in urethral reconstruction</p>	
Investigations/procedures needed	<p>Endoscopy: Cystourethoscopy (Ureteroscopy), Sigmoidoscopy, Colonoscopy Functional Assessment: Urodynamics, Ano-rectal manometry, Nerve conduction studies Imaging: CT/IVU, MRI, Ultrasound, Retrograde pyelography Initial drainage procedures: Urethral or suprapubic catheterisation of bladder, retrograde ureteric stenting, nephrostomy, antegrade ureteric stenting Diverticulum: Cystourethoscopy, urodynamics, MRI, ultrasound</p>	
Treatment Strategy (please provide detail)	<p>Outpatient</p> <p>Initial drainage procedures as above, in appropriate circumstances (best organised in discussion with Supra- regional Fistula Unit)</p>	<p>Inpatient</p> <p>Site: Supra-regional Fistula Unit Timing: Dictated by aetiology and nature of fistula Further assessment: EUA/Cystoscopy (possible retrograde pyelography) followed (within days) by: Repair Surgery: Vaginal (+/- interposition), colpocleisis, abdominal transvesical or transperitoneal (+/- interposition), ureteric re-implantation, urinary diversion (ileal conduit or continent) Diverticulum: vaginal (+/- interposition) only</p>
	<p>Site: Supra-regional Urogynaecology/Urology Fistula Unit (where feasible); Local (referring) hospital (where repeat travel difficult) Timing: 6-8 weeks following repair (unless adverse events/outcomes)</p>	
Follow up (detail)		
Further investigations/treatment srequired (detail)	<p align="center">Only if adverse events/outcomes Imaging: Cystogram/CT IVU Further assessment: EUA/Cystoscopy</p>	